

516  
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <b>Maryland</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>R.D. #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>unknown</b>							
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>W.</u> Last <u>ARO</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-27-87</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel W. Aro - Deceased</u>				14. MOTHER'S MAIDEN NAME <u>Mary Flahart - Deceased</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>216-12-3328</u> <u>unknown</u>		17. INFORMANT Address <u>Hospital Records, VAH, Perry Point, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 5, 1959</u> , to <u>January 7, 1959</u> and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above. <u>XXXXXXXXXXXXXXXXXXXX</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>M. Harris</u> M.D. <u>V.A. Hospital, Perry Point, Md.</u> <u>1-7-59</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>W. M. HARRIS</u> Acting Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Elkton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald H. Free</u> ADDRESS <u>H.W. PIPPIN &amp; SON, Elkton, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

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VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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white, blue, green, yellow, red, black, and grey.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

517

00505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, R.D.		c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Deposit R.D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) John B Astle			4. DATE OF DEATH Month 1 Day 5 Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH L-1 1888		9. AGE (In years last birthday) 71 yfs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Wesley Astle			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Annie C. Chandlee			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 212-36-5942			17. INFORMANT Mrs. Helen Astle, Port Deposit, Md. R.D.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		M.D. R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 1-6-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-9-1959		22c. NAME OF CEMETERY OR CREMATORY Rosebank	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East Md		ADDRESS North East Md		22d. LOCATION (City, town, or county) (State) Colvert Cecil Co. Md	
24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b>		c. LENGTH OF STAY IN 1b <b>13yrs1mo.18days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>451 Oxford Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>BAILEY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1889</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Elijah Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Nixon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Hospital Records, VA Hospital, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, lower lobes</b> DUE TO <b>unresolved</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis, right kidney organism unknown</b> DUE TO <b>unknown</b> (c)					INTERVAL BETWEEN ONSET AND DEATH <b>5-6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease - unknown</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Nov. 24,</b> 19 <b>45,</b> to <b>January 11,</b> 19 <b>59</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-12-59</b>					
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D.					
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SONS</b>		ADDRESS <b>Havre DeGrace, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krouse</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 306 Landing Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Mary Louisa CONFEY				4. DATE OF DEATH January 23, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22, 1877	
				9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William A. Queck				14. MOTHER'S MAIDEN NAME Susan Godshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. -----			
				17. INFORMANT Address Clement Y. Vaughan, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intestinal obstruction 174X							
DUE TO (b) Metastatic pelvic carcinoma 6 mos.							
DUE TO (c) Carcinoma of uterus 1 year.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinaria							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-19-59, to 1-23-59, that I last saw the deceased alive on 1-23-59, and that death occurred at 10:44 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter Stavrakis				ADDRESS (Street, city or town, state) 154 W MAIN			
DATE SIGNED 1-23-59							
PHYSICIAN'S NAME (Type) PETER STAVRAKIS M.D. ELKTON, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bethel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 '59	
				24b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		Male		35		April 14, 1928		Alton, Illinois		None		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
April 4, 1968		10:15 AM		St. Louis, Missouri		Myocardial Infarction		Natural		[Signature]		[Signature]		[Signatures]	
17. FULL NAME OF PHYSICIAN		18. FULL NAME OF REGISTRAR		19. FULL NAME OF WITNESSES		20. FULL NAME OF WITNESSES		21. FULL NAME OF WITNESSES		22. FULL NAME OF WITNESSES		23. FULL NAME OF WITNESSES		24. FULL NAME OF WITNESSES	
Dr. [Name]		[Name]		[Names]		[Names]		[Names]		[Names]		[Names]		[Names]	
25. FULL NAME OF WITNESSES		26. FULL NAME OF WITNESSES		27. FULL NAME OF WITNESSES		28. FULL NAME OF WITNESSES		29. FULL NAME OF WITNESSES		30. FULL NAME OF WITNESSES		31. FULL NAME OF WITNESSES		32. FULL NAME OF WITNESSES	
[Names]		[Names]		[Names]		[Names]		[Names]		[Names]		[Names]		[Names]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00508

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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>13yrs. 11mo. 27days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>928 Snows Court, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD (NMI) GARNETT</b>		4. DATE OF DEATH Month Day Year <b>January 12 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 7, 1904</b>
9. AGE (In years last birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Garnett, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Spriggs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Not available</b>		Address <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, lower lobes</b> DUE TO <b>unresolved</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Granulocytic leukemia bone marrow acute</b> DUE TO <b>unknown</b> (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 16, 1945</b> , to <b>January 13, 1958</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 1-13-59</b>			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		M.D. <b>V.A. Hospital, Perry Point, Md. 1-13-59</b>	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/14/1959</b>		22b. DATE THEREOF <b>UNKNOWN</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>UNKNOWN</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Sons</b>		ADDRESS <b>Hayre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

# CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00509

Reg. Dist. No.

520

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkmills		c. LENGTH OF STAY IN 1b all life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Walter L Gregg		4. DATE OF DEATH Month 1 Day 14 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer in Fiber Plant Fiber		10b. KIND OF BUSINESS OR INDUSTRY Cecil Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Gregg		14. MOTHER'S MAIDEN NAME Annie Scarborough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-09-3241	
17. INFORMANT Address Miss Gregg, Elkmills. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Acute Coronary Occlusion	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-15-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17./59	
22c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery		22d. LOCATION (City, town, or county) (State) Fair Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.		24a. REC'D BY REGISTRAR DATE JAN 20 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 10 1910  
DEPT. OF HEALTH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

228

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
JAMES J. JONES		35		M		W		C		M		H		C		C		JAN 10 1910		C		C		C		J. J. JONES		JAN 10 1910	
BORN		JAN 10 1875		C		W		C		M		H		C		C		JAN 10 1910		C		C		C		J. J. JONES		JAN 10 1910	
DIED		JAN 10 1910		C		W		C		M		H		C		C		JAN 10 1910		C		C		C		J. J. JONES		JAN 10 1910	
CAUSE OF DEATH		C		W		C		M		H		C		C		C		JAN 10 1910		C		C		C		J. J. JONES		JAN 10 1910	
MANNER OF DEATH		C		W		C		M		H		C		C		C		JAN 10 1910		C		C		C		J. J. JONES		JAN 10 1910	
SIGNATURE OF EXAMINER		J. J. JONES		C		W		C		M		H		C		C		JAN 10 1910		C		C		C		J. J. JONES		JAN 10 1910	
DATE		JAN 10 1910		C		W		C		M		H		C		C		JAN 10 1910		C		C		C		J. J. JONES		JAN 10 1910	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East. R.D.		c. LENGTH OF STAY IN 1b 25 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East. R.D.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle T Last Grier				4. DATE OF DEATH Month 1 Day 29 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1901		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Making Cabinets		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert T Grier				14. MOTHER'S MAIDEN NAME Ella Churchside			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-05-544+		17. INFORMANT Sara M. Grier, North East. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				DATE SIGNED 1-29-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-29-59		22c. NAME OF CEMETERY OR CREMATORY Silver Brook		22d. LOCATION (City, town, or county) (State) Wilmington, New Castle Del	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant				ADDRESS North East Md		24a. REC'D BY REGISTRAR DATE JAN 30 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Grant			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF EXAMINER</p>	
<p>11. DATE OF DEATH</p>		<p>12. TIME OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. SIGNATURE OF WITNESS</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF CLERK</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00511

522

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, Rural</b>		c. LENGTH OF STAY IN lb <b>25 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, Rural</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David Lewis Hall</b>		4. DATE OF DEATH <b>1 / 21</b> Month Day Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 / 12 / 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Bayview, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Edward Hall</b>		14. MOTHER'S MAIDEN NAME <b>Susan Rebecca Davidson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mrs. Florence Hamm Rising Sun, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertensive cerebro vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10 yrs.</b> <b>10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10</b> , 19 <b>77</b> , to <b>Jan 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>January 20</b> , 19 <b>59</b> , and that death occurred at <b>11 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>1-22-59</b>	
PHYSICIAN'S NAME (Type) <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/25/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Colora Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24a. REC'D BY REGISTRAR <b>[Signature]</b>	
ADDRESS <b>Rising Sun, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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CHARTER OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00512

523

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. STREET ADDRESS <b>Bainbridge Village, Trailer #77</b>			
3. NAME OF DECEASED (Type or print) First <b>Gail</b> Middle <b>Ann</b> Last <b>Henline</b>				4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 January 1959</b>		9. AGE (In years last birthday) yrs. <b>13</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>13</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jackie Ray Henline</b>				14. MOTHER'S MAIDEN NAME <b>Marilene Frances Foos</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6 January 1959</b> to <b>7 January 1959</b> , that I last saw the deceased alive on <b>7 January 1959</b> , and that death occurred at <b>0130AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James K. Fugate</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, Bainbridge, Md</b>			
PHYSICIAN'S NAME (Type) <b>JAMES K. FUGATE, LT MC USNR</b>				DATE SIGNED <b>1/7/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colora, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE A. PATTERSON &amp; SON</b>				ADDRESS <b>PERRYVILLE, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 1959</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Fugate</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00513

524

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gay</u> Middle <u>Marie</u> Last <u>Henline</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 January 1959</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>1</u> Hours <u>15</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Jackie Ray Henline</u>				14. MOTHER'S MAIDEN NAME <u>Marilene Frances Foos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>6 January</u> , 19 <u>59</u> , to <u>7 January</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7 January</u> , 19 <u>59</u> , and that death occurred at <u>1:350 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Allen P. Hartman</u>		M.D. <u>U. S. Naval Hospital, Bainbridge, Md.</u> 1/7/59					
PHYSICIAN'S NAME (Type) <u>ALLEN P. HARTMAN, LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>			ADDRESS <u>PERRYVILLE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>		
					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>		

225182XV2

CERTIFICATE OF DEATH

PLACE OF DEATH IN COUNTY		MARRIAGE	
DATE OF DEATH		DATE OF MARRIAGE	
TIME OF DEATH		TIME OF MARRIAGE	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
AGE		AGE	
SEX		SEX	
RACE		RACE	
BIRTH DATE		BIRTH DATE	
BIRTH PLACE		BIRTH PLACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
RELIGION		RELIGION	
MILITARY SERVICE		MILITARY SERVICE	
PREVIOUS ILLNESS		PREVIOUS ILLNESS	
TREATMENT		TREATMENT	
HISTORY OF DEATH		HISTORY OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERGYMAN		SIGNATURE OF CLERGYMAN	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF NOTARY		SIGNATURE OF NOTARY	
SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF SHERIFF		SIGNATURE OF SHERIFF	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF TOWNSHIP CLERK	
SIGNATURE OF COUNTY CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF STATE CLERK	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00514

525 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Cecil</b>		STATE <b>Md.</b>		COUNTY <b>Cecil</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Woodlawn Rd.</b>		STREET ADDRESS (If rural give location) <b>Woodlawn Rd.</b>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Grover Cleveland Jackson</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>1 20 19 59</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Said to be)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 14, 1888</b>	<b>9. AGE last birthday</b> <b>70</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Painter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>House</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>John Jackson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Jane Simmers</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No or unk.) (If Yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220-09-2466</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Eva Jackson, Port Deposit, Md. RED</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>443X IMMEDIATE CAUSE (A)</b> <b>Coronary Nucleo-Rodent</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hrs</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Hypertensive C. Nucleo-Rodent</b>						<b>5 yrs.</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Mult. pl. Embolisms of face</b>						<b>2 yrs.</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> M. et work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 12-18, 1958, to 1-20, 1959, that I last saw the deceased alive on 1-20, 1959, and that death occurred at 5:30 AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS (Street, city, town, state)</b> <b>Port Deposit, Md.</b>		<b>DATE SIGNED</b> <b>1-21-59</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>1-23, 1959</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Asbury Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Port Deposit, Md. Rural</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b> <b>Perryville, Md.</b>	
<b>DATE</b> <b>JAN 23 '59</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00515

526

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORTH EAST RURAL</b>				c. LENGTH OF STAY IN 1b <b>16 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First <b>Titus</b> Middle <b>Kataja</b> Last <b>Kataja</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>2</b> Year <b>1958</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 10, 1890</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>		IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chicken Farmer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chicken Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM OWNER</b>		11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA Naturalized 5-12-1916</b>	
13. FATHER'S NAME <b>no information</b>				14. MOTHER'S MAIDEN NAME <b>no information</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>470-10-2891</b>		17. INFORMANT <b>Mrs Helmi Kataja</b> Address <b>North East Rd 1 Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> years (c) <b>Generalized arteriosclerosis</b> years						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension, Pulmona r t Emphysema, Bronchiectasis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 7</b> , 19 <b>58</b> , to <b>Jan. 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Aug. 7</b> , 19 <b>58</b> , and that death occurred at <b>4.00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Luis M. Cuza</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>Luis M. Cuza, M.D.</b>		<b>North East, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>1-5-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, New Castle, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph P. Grant</b>				ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert E. Hous</b>			

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512

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>11</u> yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>J.</u> Last <u>Kieffer</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1894</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Kieffer</u>				14. MOTHER'S MAIDEN NAME <u>Regina Loflin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W W 1</u>		17. INFORMANT <u>Mrs. Beatrice P. Kieffer, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung, right</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and Metastatic disease of ilium</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>March-1958</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 1958, to <u>Jan. 8</u> , 1959, that I last saw the deceased alive on <u>Jan. 7</u> , 1959, and that death occurred at <u>7</u> a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>Jan. 9-1959</u>							
ACTUAL SIGNATURE <u>Milford H. Sprecher</u> M.D.				DATE SIGNED <u>Jan. 9-1959</u>			
PHYSICIAN'S NAME (Type) <u>Milford H. Sprecher, M.D.</u> <u>Elkton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park, Elkton, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel E. Hicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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 513  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 1 Film G237 1-21-59 et  
 CERTIFICATE OF DEATH

00517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At home"		d. STREET ADDRESS 219 W. High Street	
3. NAME OF DECEASED (Type or print) First Middle Last Florence C. Kirk		4. DATE OF DEATH January 11 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1882
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Cooke	
14. MOTHER'S MAIDEN NAME Margaret Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-03-0841		17. INFORMANT Mrs. Margaret Boyd, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Massive Myocardial Infarct DUE TO (b) In farct DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1953, to Jan 11, 1959 that I last saw the deceased alive on Jan. 6, 1959, and that death occurred on Jan 11, 1959, from the causes and on the date stated above.			
ACTUAL SIGNATURE Milford H. Sprecher M.D.		ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED Jan 11, 1959	
PHYSICIAN'S NAME (Type) Milford H. Sprecher M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Bethel, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00518

514

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>5 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>123 West Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Dorothy</u> Last <u>Lynch</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>8</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Hennell</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bartley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-22-9047</u>		17. INFORMANT Address <u>Mrs Doris Warrington. Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute intestinal obstruction</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant metastases of carcinoma</u> DUE TO (c) <u>Cancer of ovary</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 mos</u> <u>1-2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe secondary anemia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12:27</u> , 19 <u>58</u> , to <u>1:31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1:31</u> , 19 <u>59</u> , and that death occurred at <u>7:42</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W. Main</u> DATE SIGNED <u>2-2-59</u> ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D. <u>PETER STAVRAKIS</u> PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u> <u>ELKTON</u> <u>Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter du Bose Jr.</u> ADDRESS <u>Elkton, Md</u>				24a. REC'D BY REGISTRAR <u>FEB 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

527

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Earlville R.D.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Earlville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ann</b> Middle <b>Malley</b> Last <b>Malley</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Edmondson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tomilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Mary Holloway</b>		Address <b>415 Drexel Court Apt. Drexel Hill Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exposure Freezing weather</b> 9030 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on the lawn and could not get up</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> o. m. <b>1-9-59</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Earlville Cecil Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-10-59</b>	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>	
22b. DATE THEREOF <b>Jan. 14 1959</b>		22c. LOCATION (City, town, or county) (State) <b>Landover Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Holloway</b>		24a. REC'D BY REGISTRAR <b>JAN 15 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Edward S. H. H.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files. 4 to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of \_\_\_\_\_ State of \_\_\_\_\_

Deceased's Name \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_

1917-1918

Residence \_\_\_\_\_

Occupation \_\_\_\_\_

How long in present residence \_\_\_\_\_

How long in present occupation \_\_\_\_\_

Cause of Death \_\_\_\_\_



x

x

Death on the farm and not at home

Signature of Medical Examiner \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

1917-1918

x

1917-1918



1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00520

# CERTIFICATE OF DEATH

528

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Cecil</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Cecil</b>
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <b>Port Deposit, Rural</b>	LENGTH OF STAY (in this place) <b>Life</b>	CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN <b>Port Deposit, Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <b>Woodlawn</b>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Mary Amelia Meck</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>1 26 1959</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>Sept. 17, 1904</b>
<b>9. AGE last birthday</b> <b>54</b> yrs.		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) <b>19 59</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Fire Works Factory.</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Joseph D. Meck</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Rhoda Barnes</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-28-7757</b>	
<b>17. INFORMANT &amp; ADDRESS</b> <b>Donald Meck, Port Deposit, Md. RFD</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>171X IMMEDIATE CAUSE (A)</b> <b>Cancer Cervix &amp; Metastasis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 yr.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>			
<b>STATING UNDERLYING CAUSE LAST.</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from May 1958, to Jan 26 1959, that I last saw the deceased alive on Dec 31 1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS (Street, City, town, state)</b> <i>[Address]</i>	
<b>DATE SIGNED</b> <i>[Date]</i>		<b>DATE SIGNED</b> <i>[Date]</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>1-29-1959</b>	
<b>NAME OF CEMETERY OR CREMATORY</b> <b>hopewell cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Port Deposit, Md. R F D.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>JAN 29 '59</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	
<b>DATE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>	
		<b>ADDRESS</b> <b>Perryville, Md.</b>	

240172012/24

THIS IS A CERTIFICATE OF DEATH, ISSUED BY THE STATE OF MARYLAND, IN ACCORDANCE WITH THE PROVISIONS OF THE MARYLAND DEATH RECORDING ACT, CHAPTER 10, SECTION 1-101, OF THE MARYLAND CODE, ANNOTATED. THIS CERTIFICATE IS NOT VALID UNLESS IT IS SIGNED BY A LICENSED DEATH REGISTRAR OR A LICENSED DEATH RECORDER, AND IT IS NOT VALID UNLESS IT IS FILED IN THE OFFICE OF THE STATE ARCHIVES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF VITAL RECORDS, IN BALTIMORE, MARYLAND. THIS CERTIFICATE IS NOT VALID UNLESS IT IS FILED IN THE OFFICE OF THE STATE ARCHIVES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF VITAL RECORDS, IN BALTIMORE, MARYLAND.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DECEASED JAMES E. DOUGLAS		2. DATE OF DEATH 10-10-1971	
3. PLACE OF DEATH HOME		4. COUNTY BALTIMORE	
5. SEX MALE		6. AGE 68	
7. RACE WHITE		8. OCCUPATION RETIRED	
9. MARITAL STATUS MARRIED		10. EDUCATION HIGH SCHOOL	
11. BIRTH DATE 10-10-1903		12. BIRTH PLACE BALTIMORE, MD	
13. DEATH CAUSE HEART DISEASE		14. DEATH PLACE HOME	
15. DEATH TIME 10:00 AM		16. DEATH HOUR 10	
17. DEATH MINUTE 00		18. DEATH SECOND 00	
19. DEATH DAY 10		20. DEATH MONTH 10	
21. DEATH YEAR 1971		22. DEATH CENTURY 19	
23. DEATH DECADE 1970		24. DEATH YEAR 1971	
25. DEATH MONTH 10		26. DEATH DAY 10	
27. DEATH HOUR 10		28. DEATH MINUTE 00	
29. DEATH SECOND 00		30. DEATH CENTURY 19	
31. DEATH DECADE 1970		32. DEATH YEAR 1971	
33. DEATH MONTH 10		34. DEATH DAY 10	
35. DEATH HOUR 10		36. DEATH MINUTE 00	
37. DEATH SECOND 00		38. DEATH CENTURY 19	
39. DEATH DECADE 1970		40. DEATH YEAR 1971	
41. DEATH MONTH 10		42. DEATH DAY 10	
43. DEATH HOUR 10		44. DEATH MINUTE 00	
45. DEATH SECOND 00		46. DEATH CENTURY 19	
47. DEATH DECADE 1970		48. DEATH YEAR 1971	
49. DEATH MONTH 10		50. DEATH DAY 10	
51. DEATH HOUR 10		52. DEATH MINUTE 00	
53. DEATH SECOND 00		54. DEATH CENTURY 19	
55. DEATH DECADE 1970		56. DEATH YEAR 1971	
57. DEATH MONTH 10		58. DEATH DAY 10	
59. DEATH HOUR 10		60. DEATH MINUTE 00	
61. DEATH SECOND 00		62. DEATH CENTURY 19	
63. DEATH DECADE 1970		64. DEATH YEAR 1971	
65. DEATH MONTH 10		66. DEATH DAY 10	
67. DEATH HOUR 10		68. DEATH MINUTE 00	
69. DEATH SECOND 00		70. DEATH CENTURY 19	
71. DEATH DECADE 1970		72. DEATH YEAR 1971	
73. DEATH MONTH 10		74. DEATH DAY 10	
75. DEATH HOUR 10		76. DEATH MINUTE 00	
77. DEATH SECOND 00		78. DEATH CENTURY 19	
79. DEATH DECADE 1970		80. DEATH YEAR 1971	
81. DEATH MONTH 10		82. DEATH DAY 10	
83. DEATH HOUR 10		84. DEATH MINUTE 00	
85. DEATH SECOND 00		86. DEATH CENTURY 19	
87. DEATH DECADE 1970		88. DEATH YEAR 1971	
89. DEATH MONTH 10		90. DEATH DAY 10	
91. DEATH HOUR 10		92. DEATH MINUTE 00	
93. DEATH SECOND 00		94. DEATH CENTURY 19	
95. DEATH DECADE 1970		96. DEATH YEAR 1971	
97. DEATH MONTH 10		98. DEATH DAY 10	
99. DEATH HOUR 10		100. DEATH MINUTE 00	
101. DEATH SECOND 00		102. DEATH CENTURY 19	
103. DEATH DECADE 1970		104. DEATH YEAR 1971	
105. DEATH MONTH 10		106. DEATH DAY 10	
107. DEATH HOUR 10		108. DEATH MINUTE 00	
109. DEATH SECOND 00		110. DEATH CENTURY 19	
111. DEATH DECADE 1970		112. DEATH YEAR 1971	
113. DEATH MONTH 10		114. DEATH DAY 10	
115. DEATH HOUR 10		116. DEATH MINUTE 00	
117. DEATH SECOND 00		118. DEATH CENTURY 19	
119. DEATH DECADE 1970		120. DEATH YEAR 1971	
121. DEATH MONTH 10		122. DEATH DAY 10	
123. DEATH HOUR 10		124. DEATH MINUTE 00	
125. DEATH SECOND 00		126. DEATH CENTURY 19	
127. DEATH DECADE 1970		128. DEATH YEAR 1971	
129. DEATH MONTH 10		130. DEATH DAY 10	
131. DEATH HOUR 10		132. DEATH MINUTE 00	
133. DEATH SECOND 00		134. DEATH CENTURY 19	
135. DEATH DECADE 1970		136. DEATH YEAR 1971	
137. DEATH MONTH 10		138. DEATH DAY 10	
139. DEATH HOUR 10		140. DEATH MINUTE 00	
141. DEATH SECOND 00		142. DEATH CENTURY 19	
143. DEATH DECADE 1970		144. DEATH YEAR 1971	
145. DEATH MONTH 10		146. DEATH DAY 10	
147. DEATH HOUR 10		148. DEATH MINUTE 00	
149. DEATH SECOND 00		150. DEATH CENTURY 19	
151. DEATH DECADE 1970		152. DEATH YEAR 1971	
153. DEATH MONTH 10		154. DEATH DAY 10	
155. DEATH HOUR 10		156. DEATH MINUTE 00	
157. DEATH SECOND 00		158. DEATH CENTURY 19	
159. DEATH DECADE 1970		160. DEATH YEAR 1971	
161. DEATH MONTH 10		162. DEATH DAY 10	
163. DEATH HOUR 10		164. DEATH MINUTE 00	
165. DEATH SECOND 00		166. DEATH CENTURY 19	
167. DEATH DECADE 1970		168. DEATH YEAR 1971	
169. DEATH MONTH 10		170. DEATH DAY 10	
171. DEATH HOUR 10		172. DEATH MINUTE 00	
173. DEATH SECOND 00		174. DEATH CENTURY 19	
175. DEATH DECADE 1970		176. DEATH YEAR 1971	
177. DEATH MONTH 10		178. DEATH DAY 10	
179. DEATH HOUR 10		180. DEATH MINUTE 00	
181. DEATH SECOND 00		182. DEATH CENTURY 19	
183. DEATH DECADE 1970		184. DEATH YEAR 1971	
185. DEATH MONTH 10		186. DEATH DAY 10	
187. DEATH HOUR 10		188. DEATH MINUTE 00	
189. DEATH SECOND 00		190. DEATH CENTURY 19	
191. DEATH DECADE 1970		192. DEATH YEAR 1971	
193. DEATH MONTH 10		194. DEATH DAY 10	
195. DEATH HOUR 10		196. DEATH MINUTE 00	
197. DEATH SECOND 00		198. DEATH CENTURY 19	
199. DEATH DECADE 1970		200. DEATH YEAR 1971	
201. DEATH MONTH 10		202. DEATH DAY 10	
203. DEATH HOUR 10		204. DEATH MINUTE 00	
205. DEATH SECOND 00		206. DEATH CENTURY 19	
207. DEATH DECADE 1970		208. DEATH YEAR 1971	
209. DEATH MONTH 10		210. DEATH DAY 10	
211. DEATH HOUR 10		212. DEATH MINUTE 00	
213. DEATH SECOND 00		214. DEATH CENTURY 19	
215. DEATH DECADE 1970		216. DEATH YEAR 1971	
217. DEATH MONTH 10		218. DEATH DAY 10	
219. DEATH HOUR 10		220. DEATH MINUTE 00	
221. DEATH SECOND 00		222. DEATH CENTURY 19	
223. DEATH DECADE 1970		224. DEATH YEAR 1971	
225. DEATH MONTH 10		226. DEATH DAY 10	
227. DEATH HOUR 10		228. DEATH MINUTE 00	
229. DEATH SECOND 00		230. DEATH CENTURY 19	
231. DEATH DECADE 1970		232. DEATH YEAR 1971	
233. DEATH MONTH 10		234. DEATH DAY 10	
235. DEATH HOUR 10		236. DEATH MINUTE 00	
237. DEATH SECOND 00		238. DEATH CENTURY 19	
239. DEATH DECADE 1970		240. DEATH YEAR 1971	
241. DEATH MONTH 10		242. DEATH DAY 10	
243. DEATH HOUR 10		244. DEATH MINUTE 00	
245. DEATH SECOND 00		246. DEATH CENTURY 19	
247. DEATH DECADE 1970		248. DEATH YEAR 1971	
249. DEATH MONTH 10		250. DEATH DAY 10	
251. DEATH HOUR 10		252. DEATH MINUTE 00	
253. DEATH SECOND 00		254. DEATH CENTURY 19	
255. DEATH DECADE 1970		256. DEATH YEAR 1971	
257. DEATH MONTH 10		258. DEATH DAY 10	
259. DEATH HOUR 10		260. DEATH MINUTE 00	
261. DEATH SECOND 00		262. DEATH CENTURY 19	
263. DEATH DECADE 1970		264. DEATH YEAR 1971	
265. DEATH MONTH 10		266. DEATH DAY 10	
267. DEATH HOUR 10		268. DEATH MINUTE 00	
269. DEATH SECOND 00		270. DEATH CENTURY 19	
271. DEATH DECADE 1970		272. DEATH YEAR 1971	
273. DEATH MONTH 10		274. DEATH DAY 10	
275. DEATH HOUR 10		276. DEATH MINUTE 00	
277. DEATH SECOND 00		278. DEATH CENTURY 19	
279. DEATH DECADE 1970		280. DEATH YEAR 1971	
281. DEATH MONTH 10		282. DEATH DAY 10	
283. DEATH HOUR 10		284. DEATH MINUTE 00	
285. DEATH SECOND 00		286. DEATH CENTURY 19	
287. DEATH DECADE 1970		288. DEATH YEAR 1971	
289. DEATH MONTH 10		290. DEATH DAY 10	
291. DEATH HOUR 10		292. DEATH MINUTE 00	
293. DEATH SECOND 00		294. DEATH CENTURY 19	
295. DEATH DECADE 1970		296. DEATH YEAR 1971	
297. DEATH MONTH 10		298. DEATH DAY 10	
299. DEATH HOUR 10		300. DEATH MINUTE 00	
301. DEATH SECOND 00		302. DEATH CENTURY 19	
303. DEATH DECADE 1970		304. DEATH YEAR 1971	
305. DEATH MONTH 10		306. DEATH DAY 10	
307. DEATH HOUR 10		308. DEATH MINUTE 00	
309. DEATH SECOND 00		310. DEATH CENTURY 19	
311. DEATH DECADE 1970		312. DEATH YEAR 1971	
313. DEATH MONTH 10		314. DEATH DAY 10	
315. DEATH HOUR 10		316. DEATH MINUTE 00	
317. DEATH SECOND 00		318. DEATH CENTURY 19	
319. DEATH DECADE 1970		320. DEATH YEAR 1971	
321. DEATH MONTH 10		322. DEATH DAY 10	
323. DEATH HOUR 10		324. DEATH MINUTE 00	
325. DEATH SECOND 00		326. DEATH CENTURY 19	
327. DEATH DECADE 1970		328. DEATH YEAR 1971	
329. DEATH MONTH 10		330. DEATH DAY 10	
331. DEATH HOUR 10		332. DEATH MINUTE 00	
333. DEATH SECOND 00		334. DEATH CENTURY 19	
335. DEATH DECADE 1970		336. DEATH YEAR 1971	
337. DEATH MONTH 10		338. DEATH DAY 10	
339. DEATH HOUR 10		340. DEATH MINUTE 00	
341. DEATH SECOND 00		342. DEATH CENTURY 19	
343. DEATH DECADE 1970		344. DEATH YEAR 1971	
345. DEATH MONTH 10		346. DEATH DAY 10	
347. DEATH HOUR 10		348. DEATH MINUTE 00	
349. DEATH SECOND 00		350. DEATH CENTURY 19	
351. DEATH DECADE 1970		352. DEATH YEAR 1971	
353. DEATH MONTH 10		354. DEATH DAY 10	
355. DEATH HOUR 10		356. DEATH MINUTE 00	
357. DEATH SECOND 00		358. DEATH CENTURY 19	
359. DEATH DECADE 1970		360. DEATH YEAR 1971	
361. DEATH MONTH 10		362. DEATH DAY 10	
363. DEATH HOUR 10		364. DEATH MINUTE 00	
365. DEATH SECOND 00		366. DEATH CENTURY 19	
367. DEATH DECADE 1970		368. DEATH YEAR 1971	
369. DEATH MONTH 10		370. DEATH DAY 10	
371. DEATH HOUR 10		372. DEATH MINUTE 00	
373. DEATH SECOND 00		374. DEATH CENTURY 19	
375. DEATH DECADE 1970		376. DEATH YEAR 1971	
377. DEATH MONTH 10		378. DEATH DAY 10	
379. DEATH HOUR 10		380. DEATH MINUTE 00	
381. DEATH SECOND 00		382. DEATH CENTURY 19	
383. DEATH DECADE 1970		384. DEATH YEAR 1971	
385. DEATH MONTH 10		386. DEATH DAY 10	
387. DEATH HOUR 10		388. DEATH MINUTE 00	
389. DEATH SECOND 00		390. DEATH CENTURY 19	
391. DEATH DECADE 1970		392. DEATH YEAR 1971	
393. DEATH MONTH 10		394. DEATH DAY 10	
395. DEATH HOUR 10		396. DEATH MINUTE 00	
397. DEATH SECOND 00		398. DEATH CENTURY 19	
399. DEATH DECADE 1970		400. DEATH YEAR 1971	
401. DEATH MONTH 10		402. DEATH DAY 10	
403. DEATH HOUR 10		404. DEATH MINUTE 00	
405. DEATH SECOND 00		406. DEATH CENTURY 19	
407. DEATH DECADE 1970		408. DEATH YEAR 1971	
409. DEATH MONTH 10		410. DEATH DAY 10	
411. DEATH HOUR 10		412. DEATH MINUTE 00	
413. DEATH SECOND 00		414. DEATH CENTURY 19	
415. DEATH DECADE 1970		416. DEATH YEAR 1971	
417. DEATH MONTH 10		418. DEATH DAY 10	
419. DEATH HOUR 10		420. DEATH MINUTE 00	
421. DEATH SECOND 00		422. DEATH CENTURY 19	
423. DEATH DECADE 1970		424. DEATH YEAR 1971	
425. DEATH MONTH 10		426. DEATH DAY 10	
427. DEATH HOUR 10		428. DEATH MINUTE 00	
429. DEATH SECOND 00		430. DEATH CENTURY 19	
431. DEATH DECADE 1970		432. DEATH YEAR 1971	
433. DEATH MONTH 10		434. DEATH DAY 10	
435. DEATH HOUR 10		436. DEATH MINUTE 00	
437. DEATH SECOND 00		438. DEATH CENTURY 19	
439. DEATH DECADE 1970		440. DEATH YEAR 1971	
441. DEATH MONTH 10		442. DEATH DAY 10	
443. DEATH HOUR 10		444. DEATH MINUTE 00	
445. DEATH SECOND 00		446. DEATH CENTURY 19	
447. DEATH DECADE 1970		448. DEATH YEAR 1971	
449. DEATH MONTH 10		450. DEATH DAY 10	
451. DEATH HOUR 10		452. DEATH MINUTE 00	
453. DEATH SECOND 00		454. DEATH CENTURY 19	
455. DEATH DECADE 1970		456. DEATH YEAR 1971	
457. DEATH MONTH 10		458. DEATH DAY 10	
459. DEATH HOUR 10		460. DEATH MINUTE 00	
461. DEATH SECOND 00		462. DEATH CENTURY 19	
463. DEATH DECADE 1970		464. DEATH YEAR 1971	
465. DEATH MONTH 10		466. DEATH DAY 10	
467. DEATH HOUR 10		468. DEATH MINUTE 00	
469. DEATH SECOND 00		470. DEATH CENTURY 19	
471. DEATH DECADE 1970		472. DEATH YEAR 1971	
473. DEATH MONTH 10		474. DEATH DAY 10	
475. DEATH HOUR 10		476. DEATH MINUTE 00	
477. DEATH SECOND 00		478. DEATH CENTURY 19	
479. DEATH DECADE 1970		480. DEATH YEAR 1971	
481. DEATH MONTH 10		482. DEATH DAY 10	
483. DEATH HOUR 10		484. DEATH MINUTE 00	
485. DEATH SECOND 00		486. DEATH CENTURY 19	
487. DEATH DECADE 1970		488. DEATH YEAR 1971	
489. DEATH MONTH 10		490. DEATH DAY 10	
491. DEATH HOUR 10		492. DEATH MINUTE 00	
493. DEATH SECOND 00		494. DEATH CENTURY 19	
495. DEATH DECADE 1970		496. DEATH YEAR 19	

00521

529

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>				c. LENGTH OF STAY IN 1b <u>10yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>George St.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
f. STREET ADDRESS <u>George St.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>NORRIS</u> Last <u>NORRIS</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7 1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>P12 14 3380</u>		17. INFORMANT <u>Ellen Savin Chesapeake Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:15</u> 19 <u>57</u> to <u>DECEASED</u> 19 <u>59</u> that I last saw the deceased alive on <u>Jan 15</u> 19 <u>59</u> and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Davis</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesapeake City MD</u> DATE SIGNED <u>1/16/59</u>			
PHYSICIAN'S NAME (Type) <u>HENRY V DAVIS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/18/59</u>		<u>Bethel Cem</u>		<u>Bethel MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter du Boeuf</u>				ADDRESS <u>Elkton, MD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]	
AGE [Handwritten: 45]		DATE OF BIRTH [Handwritten: 10/15/1900]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		OCCUPATION [Handwritten: Clerk]	
MARITAL STATUS [Handwritten: Married]		DATE OF MARRIAGE [Handwritten: 08/10/1925]	
NAME OF WIFE [Handwritten: Jane Doe]		NAME OF HUSBAND [Handwritten: John Doe]	
CAUSE OF DEATH [Handwritten: Myocardial Infarction]		PLACE OF DEATH [Handwritten: Home]	
DATE OF DEATH [Handwritten: 11/10/1945]		TIME OF DEATH [Handwritten: 10:15 AM]	
SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]		SIGNATURE OF REGISTRAR [Handwritten: M. J. Brown]	
SIGNATURE OF WITNESS [Handwritten: A. C. White]		SIGNATURE OF WITNESS [Handwritten: B. D. Green]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00522

Reg. Dist. No. 96

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>5yrs. 5mo. 22days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			e. STREET ADDRESS <b>3627 Eitemiller Road</b>		
3. NAME OF DECEASED (Type or print) <b>WALLACE F. POWELL</b>			4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-23</b>		9. AGE (In years last birthday) <b>35</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Basil Powell</b>			14. MOTHER'S MAIDEN NAME <b>Florabell Herndon</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes Korean Conflict</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>R. C. DODSON</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-15-59</b>	
EXAMINER'S NAME (Type) <b>R. C. DODSON</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>1/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) <b>Ft. Myer, Virginia.</b>		(State) <b>Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		ADDRESS <b>Hyve DeGrace, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2001

County Point

John. No. 1234

Height

1927 11-11-1927

1-24-22

WABACK

1-24-22

1-24-22

Male

White

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22

1-24-22



531

CERTIFICATE OF DEATH

00523

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN lb <b>3mos14days</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VA Hospital, Perry Point, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. CITY <b>Washington</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>A.</b> Last <b>PRILLAMAN</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>2,</b> Year <b>19 59</b>				5. SEX <b>Male</b>				6. COLOR OR RACE <b>Negro</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>8-8-18</b>				9. AGE (In years last birthday) <b>40</b> yrs.				IF UNDER 1 YEAR Months <b>40</b> Days <b>40</b> Hours <b>40</b> Min. <b>40</b>				IF UNDER 24 HRS. Months <b>40</b> Days <b>40</b> Hours <b>40</b> Min. <b>40</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Wayland Prillaman</b>				14. MOTHER'S MAIDEN NAME <b>Leathia Torrence</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes. WWII</b>				16. SOCIAL SECURITY NO. <b>579 05 0484</b>				17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic glomerulo-nephritis</b> DUE TO (c) <b>Hypertensive cardia vascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>over 5 yrs.</b> <b>over 5 yrs.</b> <b>over 5 yrs.</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left ventricular hypertrophy and myocardial edema</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from <b>Sept 18,</b> 19 <b>58,</b> to <b>Jan. 2,</b> 19 <b>59</b> and that death occurred at <b>4:50P</b> M, from the causes and on the date stated above.																ADDRESS (Street, city or town, state)				DATE SIGNED															
ACTUAL SIGNATURE <b>E. S. Ellis</b>				M.D. <b>Acting Dir. Prof. Services,</b>				PHYSICIAN'S NAME (Type) <b>E. S. ELLS, M.D.</b>				VA Hospital, Perry Point, Maryland.																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>1/6/1959</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Ft. Myer, Va.</b>				22d. LOCATION (City, town, or county) (State)																							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington, Son</b>				ADDRESS <b>de Grace, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 9 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 532

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

00524

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>3yrs. 7 mo.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Hyattsville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>8905 Riggs Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>O.</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-88</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>16</b> Hours <b>15</b> Min. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Robinson -(deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Laura Insley (deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia (following operation)</b> DUE TO <b>540.0</b> bilateral, unresolved Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gastroenterostomy, posterior for bleeding</b> DUE TO <b>duodenal ulcer 1-17-59</b> (c) <b>Arteriosclerosis, generalized, severe</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>24-48 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Arteriosclerosis, generalized, severe</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22</b> , 19 <b>55</b> , to <b>January 21</b> , 19 <b>59</b> . and that death occurred at <b>2:07 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 1-22-59</b>			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 26, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Takoma Funeral Home, Takoma Park, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CENTRE OF DEATH

532

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

Name		Address		City		State		Zip	
William J. Robinson - (deceased)		Laura Leahy (deceased)		Boston		Massachusetts		02118	
Date of Birth		Date of Death		Cause of Death		Place of Death		Time of Death	
12-20-02		12-20-02		Heart Disease		Home		10:00 PM	
Sex		Age		Occupation		Education		Religion	
Male		45		School		High School		Catholic	
Marital Status		Previous Marriages		Children		Siblings		Other Relatives	
Married		None		3		2		1	
Occupation		Previous Occupations		Education		Religion		Other	
Teacher		None		High School		Catholic		None	
Cause of Death		Place of Death		Time of Death		Date of Death		Date of Burial	
Heart Disease		Home		10:00 PM		12-20-02		12-20-02	
Place of Burial		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition	
St. Mary's Cemetery		12-20-02		12-20-02		None		None	
Disposition		Remarks		Signature		Title		Date	
Buried		None		[Signature]		Registrar		12-20-02	

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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belair</b> <b>12X-2</b>			
c. LENGTH OF STAY IN 1b <b>11 days</b>				d. STREET ADDRESS <b>R.D. #2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>T.</b> Last <b>RUGGLES</b>				4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-19-18</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Army Chemical Center</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John F. Ruggles</b>				14. MOTHER'S MAIDEN NAME <b>Helen M. Weir (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>140-05-8883</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Infarction of the myocardium due to</b> DUE TO <b>arteriosclerotic coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Arteriosclerotic heart disease</b> DUE TO <b>unknown</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized moderate</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>X</del> attended the deceased from <b>January 19, 19 59, to January 30, 19 59</b> , and that death occurred at <b>2:00 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-30-59</b>							
ACTUAL SIGNATURE <b>S. P. LACERVA</b>				PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 2, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury</b>		22d. LOCATION (City, town, or county) (State) <b>Abingdon, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas</b>				ADDRESS <b>Abingdon, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

2

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I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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Exp. S. 1973

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00526

534

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>11810 Ellington Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-89</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Coalsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Smith - Deceased</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Johnson - Deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial fibrosis moderately severe</b> DUE TO <b>intraventricular septum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease, severe</b> DUE TO <b>unknown</b> (c) <b>unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>December 9, 19 58</b> , to <b>January 19, 19 59</b> , and that death occurred at <b>1:50 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-20-59</b>			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		PHYSICIAN'S NAME (Type) <b>Director, Professional Services</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>1/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU ONE

Name of Deceased		John S. Smith	
Sex		Male	
Race		White	
Date of Birth		11-25-22	
Place of Birth		Martinsburg, W. Va.	
Usual Residence		Martinsburg, W. Va.	
Date of Death		1-10-23	
Place of Death		Martinsburg, W. Va.	
Cause of Death		Tuberculosis of the lungs	
Immediate Cause		Tuberculosis of the lungs	
Underlying Cause		Tuberculosis of the lungs	
Contributing Cause		Tuberculosis of the lungs	
Manner of Death		Natural	
Signature of Physician		J. P. McGowan	
Signature of Registrar		Director, West Virginia State Department of Health	
Date of Registration		1-10-23	
Place of Registration		Martinsburg, W. Va.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00527

## CERTIFICATE OF DEATH

Reg. Dist. No.

535

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Goododds Farm RD4 Elkton Md.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard T. Taylor</u>		4. DATE OF DEATH Month Day Year <u>1 3 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (In years last birthday) yrs. <u>48</u> IF UNDER 1 YEAR Months Days Hours Min. <u>1 3 15 9</u>
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M.</u>		14. MOTHER'S MAIDEN NAME <u>Molly A. Fitzpatrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Helen Taylor</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of colon</u> DUE TO (c) <u>retroperitoneal lymphocarcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 mo</u> <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 16, 1958</u> , to <u>Jan 3, 1959</u> , that I last saw the deceased alive on <u>Jan 3, 1959</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace M. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>257 E. Main St Newark, Dola</u>	
DATE SIGNED <u>1/6/59</u>			
PHYSICIAN'S NAME (Type) <u>WALLACE M. JOHNSON M.D</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Ashland</u>		22d. LOCATION (City, town, or county) (State) <u>Ashland Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Piffin Funeral Home</u>		ADDRESS <u>W. H. Piffin Elkton, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	









536

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George C. Travers</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> , Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-83</b>
9. AGE (In years last birthday) <b>75</b>		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not Ascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>Aberdeen, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Travers (D)</b>		14. MOTHER'S MAIDEN NAME <b>Emma Creswell (D)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Hospital Records VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis with posterior myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Pulmonary emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4220</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 wks</b> <b>Past 10 yrs</b> <b>3 or 4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary infarction right side</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-9</b> , 19 <b>58</b> , to <b>1-11</b> , 19 <b>59</b> , and that death occurred at <b>11:20 A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-11-59</b>	
ACTUAL SIGNATURE <b>W. M. Harris</b> M.D.		PHYSICIAN'S NAME (Type) <b>W. M. Harris, M.D. Acting Director, Professional Services</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify). <b>BURIAL</b> <b>1/15/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Baker's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Harris</b>		24a. REC'D BY REGISTRAR <b>19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

536

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF CLERK: [illegible]

SIGNATURE OF JUDGE: [illegible]

SIGNATURE OF SHERIFF: [illegible]

SIGNATURE OF CORONER: [illegible]

SIGNATURE OF JURY: [illegible]

SIGNATURE OF COURT: [illegible]

SIGNATURE OF COUNTY: [illegible]

SIGNATURE OF STATE: [illegible]

SIGNATURE OF UNION: [illegible]

SIGNATURE OF NATION: [illegible]

SIGNATURE OF WORLD: [illegible]

SIGNATURE OF UNIVERSE: [illegible]

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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>18yrs.5mo.22days</b> <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>1006 N. Calhoun</b>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>H.</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-17-95</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Rachael Hutton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral valve insufficiency of, chronic</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 31</b> , 19 <b>40</b> , to <b>January 22</b> , 19 <b>59</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. <b>V.A. Hospital, Perry Point, Md. 1-22-59</b>							
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b> Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George E. Kelson</b> ADDRESS <b>1348 N. Calhoun St. Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>Jan 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlin S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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NAME

DATE

PLACE OF BIRTH

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE

TIME

CAUSE

DIAGNOSIS

REPORT

DATE OF BURIAL

PLACE OF BURIAL

NAME OF PHYSICIAN

DATE

NAME OF HOSPITAL

NAME OF NURSE

NAME OF REGISTRAR

DATE

NAME OF REGISTRAR

NAME OF REGISTRAR

NAME OF REGISTRAR

NAME OF REGISTRAR